

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS584HHA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/14/2009
NAME OF PROVIDER OR SUPPLIER GENTIVA HEALTH SERVICES II		STREET ADDRESS, CITY, STATE, ZIP CODE 505 EAST CAPOVILLA, SUITE #104 LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 00	<p>INITIAL COMMENTS</p> <p>Surveyor: 27469 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 10/14/09, in accordance with Nevada Administrative Code, Chapter 449, Home Health Agencies.</p> <p>Complaint #NV00023216 was substantiated with deficiencies cited. (See Tag 200)</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	H 00		
H200 SS=D	<p>449.800 Medical Orders</p> <p>8. New orders are required when there is a change in orders, a change of physician or following hospitalization. This Regulation is not met as evidenced by: Surveyor: 27469 Based on clinical record review, policy review and interview, the agency failed to notify the physician in a change of condition for 1 of 1 patients reviewed (Patient #1).</p> <p>On 9/14/09, the Director of Rehabilitation, assessed the patient and noted a decrease in her ability to sit, ambulate and transfer.</p> <p>On 10/14/09 at 11:00 AM, , Director of Rehabilitation (DR) stated he notified the Director of Clinical Management (DOCM) of the patient's wish to transfer services to another agency. He requested DOCM call the physician to request an order for change of services. The DR stated he</p>	H200		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H200	<p>Continued From page 1</p> <p>requested DOCM to notify the physician in the patient's change of condition.</p> <p>On 10/14/09 at 11:15 AM, the Director of Clinical Management stated she was notified to call the physician for change of agencies, but was not notified of the change in patient condition. DOCM stated it was the clinician's responsibility to notify the physician of a change in a patient's condition. Refer to Policy 3-16; Case Communication, #1, #2 and #3.</p> <p>Severity: 2 Scope: 1</p>	H200			

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